

THE MEDICALIZATION OF INTERSEXUALITY AND THE SEX/GENDER BINARY SYSTEM: A LOOK ON THE ITALIAN CASE¹

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ABSTRACT

The fact that the human variety is not dual is inscribed in the bodies of intersex people, persons whose chromosomal, gonadic or anatomic sexual development is atypical. The majority of intersex conditions are not visible at birth; for those born with a visible condition the usual practice, since the second half of twentieth century, has been early surgical aesthetic intervention and hormonal therapy during childhood to orient the sexual characteristics to “one of the two sexes” considered socially and culturally acceptable. The negotiation between intersex associations, scientists, scholars, and the medical class and psychotherapists, has provoked a change in protocols more centered on the patient’s care; but it remains the fact that intersexuality is generally still seen as a pathology and those aesthetic unnecessary surgeries, which have painful and irreversible effects (as intersex adults testify) continue to be practiced. This is part of a broader qualitative and quantitative sociological research I have been conducting through different tools: for the qualitative part I have adopted an approach based on in-depth narrative interviews with intersex persons; explorative interviews with privileged informants such as LGBTQ activists and members of the medical profession; a digital ethnography on national and international intersex/DSD forums and web articles and on my participation to various GLBTIQ mailing lists.

KEYWORDS

Intersexuality/Disorders of Sex Development; gender binary system; Pathologisation; Human rights.

1. INTERSEXUALITY AND DSD: NOT ONLY A TERMINOLOGICAL ISSUE

One of the most widespread and pervasive dichotomy in Western societies is the one between female and male, that is also one of the most given for granted, and considered “natural”, with direct and indirect social effects even more diriment on each individual. But the fact that the human reality is more complex and various also from the biological point of view, and that this complexity cannot simply be ascribed to the strict sex/gender binarism, is written

¹This paper represents a revision and update of my current sociological research and of other works of mine, in particular of *Sexual and Human Rights of Intersex People: the Sociological Aspects of Medicalization of Intersexuality in Italy*, in Antosa (Ed.).

into the bodies of intersex people²: persons whose chromosomal, gonadic or anatomic sexual development is atypical.

The terms intersex and intersexuality³ refer to a great variety of conditions in which a person can be born with a genetic and/or gonadic atypical set, or hormonal variations, and/or with a sexual anatomy that does not fit the usual characteristics and definitions of female and male.

There is a current debate about the terminology: most of the medical professions, many intersex parents, some intersex activists and associations⁴ have agreed to replace the terms intersex/uality with the new one Disturbs of Sexual Development (DSD) to avoid conflating matters of anatomic/gonadic/chromosomal sex with sexual preference or gender identity, and to refer to the most recent specific medical classification of the intersex conditions. On the other hand, some other intersex activists and associations, some scholars, academics and also medical professionals prefer to keep using the terms intersex/uality, because they believe DSD incorrectly suggests that intersex is always and only a pathological condition since the terminology Disturbs of Sexual Development implies illness, abnormality and deviance and it represents and ratifies a pathologization of intersex persons. As the new “Brief Guideline for Intersex Allies”, written by Organization Intersex International (OII), states intersex people need health care just as everyone else does and «there are few instances when a child's intersex variation poses health risks that require immediate medical attention»⁵. Moreover, «the term “intersex” is preferable since it includes all the different variations without implying that they have any medical condition in common which they do not».

I generally use the terms intersex/uality in agreement with the latter stance and with those who emphasize the importance of carefully selecting a respectful and non-pathologizing language. In this respect, since some other interested persons do not recognize themselves in the terms “intersex” and “intersexuality”⁶, I also interchangeably use the acronym “dsd”, in lower case, with which I intend to mean “differences (or variations) of sexual development” instead of “disturbs” and “disorders”⁷.

On the other hand, the use of intersex terminology is certainly useful to emphasize the socio-

2 I recall here one of OII's posters which states: «*The fact that the binary sex system is a fiction is written in the bodies of intersex people*» <http://oii.org.au/category/media/oii-posters/page/2/> (last accessed April 2014).

3 From now on intersex/uality.

4 Also ISNA, which was the first intersex association in the USA, in its last years had chosen to use the acronym DSD, even if the association considered intersexuality a “variation” rather than a “disorder” (http://www.isna.org/faq/what_is_intersex, last accessed April 2014).

5 «Rather, intersex people, like all people, sometimes have health issues. For example, being a female is not in and of itself a health problem, but there are health problems specific to being “female”, such as ovarian cancer.» (<http://oii-usa.org/wp-content/uploads/2012/10/Brief-Guidelines-for-Intersex-Allies.pdf>, p.1 last accessed October 2013).

6 Some other persons who use the term intersex for themselves refuse “intersexuality” since they fear that it can be associated with sexuality instead of with “sex the fact”.

7 The same terminological and epistemological change I am suggesting for DSD has already been done in the case of the Disturb of Gender Identity, which the DSM-V has renamed to Difference of Gender Identity. Some others, instead, suggest using the acronym AGIO for “Atypical Gender Identity Organization” (Di Ceglie 2003).

cultural and political dimensions of the intersex/dsd situation and the dominant sex/gender dichotomy in our society. The concept of intersex can help to reveal and deconstruct the sex/gender binarism orthodoxy, which is interconnected with other dichotomies linked to gender identities, gender roles and sexual orientation.

Intersex bodies, but also “intersex chromosomes” and “intersex gonads” show that human variety in biology is richer and more complex. Notwithstanding that contemporary human biology and ethology has widely demonstrated and confirmed that the animal and human worlds present many variations in bodies and in sexual behaviors (Fausto Sterling 2000, Tripodi V. 2011), our society continues to have difficulties in understanding and embracing the naturalness of human differences in sex, gender identities and sexual orientation.

2. THE MEDICALIZATION OF INTERSEXUALITY AND THE RESEARCH OBJECTIVES

The majority of intersex conditions are not visible at birth. This is the case, for example, with girls born with a “complete androgen insensitivity syndrome” (CAIS): in general they have external genitals that look typically female and they may discover their XY chromosomes at puberty when they undergo medical examinations to determine the reasons for the absence of menarche. Similarly, “XXY persons”⁸ may discover their intersex situation while undergoing examinations to determine the causes of their infertility (and not all those men are infertile).

Instead, for individuals born with a visible intersex condition, the usual practice in most Western countries has been early surgical intervention and hormonal therapy starting in childhood. In fact, within the medical community the predominant protocol since the second half of last century has been to decide on a sex/gender for the child and to construct an “appropriate” genitalia as early as possible for what physicians called the “psycho-social health” of the intersex child (Kessler 1996).

The cases of atypical genital (which do not fit the typical definitions of female and male) represent a minority of cases. The majority of cases consist of genetic set or chromosome map to which do not correspond a visible intersex anatomy. For example, according to Schober (2001), the above mentioned “Klinefelter’s syndrome” occurs in 1 of 1000 births⁹, the “mosaicism” (referring to those whose chromosome map is neither XX nor XY) occurs in 1 of 1,666 births, “androgen insensitivity syndrome” occurs in 1 of 13,000 births, “partial androgen insensitivity syndrome” occurs in 1 of 130,000 births, “ovotestes” (also called “true

⁸ They are individuals with XXY sexual chromosomes; this situation is also known as “Klinefelter’s syndrome” from the name of Dr. Harry Klinefelter who described it for the first time in 1942.

⁹ It is estimated that one in every 500 males have an “additional X chromosome” but do not have the “syndrome” (http://www.nichd.nih.gov/health/topics/klinefelter_syndrome.cfm, accessed May 2010).

hermaphroditism”) occurs in 1 of 83,000 births. The Intersex Society of North America (ISNA)¹⁰ reports that the 1% of human births have a certain degree of intersexuality and Anne Fausto Sterling writes that the 1.7% of births are intersex. The rate of occurrence of intersex is still uncertain also because of the invisibilization of the conditions and the socio-cultural pressure to normalize it precociously; moreover, as OII suggests there will never be a clear definition of intersex since we have no clear definitions for what a woman is or a man is¹¹. But the most important point is that human biology as well as the animal world presents us with more than two standard sexes.

The paradox is that the more is known about human biological complexity and diversity, the more is done from a medical standpoint to eliminate such diversity and to reconduct it to social gender/sex binarism. In fact, for those persons born with a visible intersex condition the usual practice, since the second half of twentieth century, has been early surgical aesthetic intervention and hormonal therapy during childhood to “normalize” the genitalia and to orient the secondary sexual characteristics to “one of the two sexes” considered socially and culturally acceptable.

In the last decades the negotiation between intersex associations, scientists, scholars, and the medical class, has provoked a change in protocols more centered on the patient’s care (Wiesemann 2010, Diamond - Sigmundson 1997). But it remains the fact that intersexuality is generally still seen as a pathology, as a “disturb of sex development”, and those pharmacological treatments and aesthetic unnecessary surgeries, which have painful and irreversible effects, as intersex adults testify, continue to be practiced (Arfini 2012).

My project aims to investigate, with an interdisciplinary approach, the medical and social practices adopted in the management of intersexuality in Italy. The main goals of the research have been:

- (a) to investigate the socio-cultural changes in commonly adopted intersex protocols over time and their significance for the social actors involved (professionals and intersex persons);
- (b) to document the day-to-day experiences of intersex people, and their points of view on medicalization and on their civil, sexual and human rights;
- (c) to analyze the viewpoints and experiences of the other social actors involved, such as intersex parents and GLBTQ (gay, lesbian, bisexual, transgender, and queer) activists.

To explore these issues in this phase of my investigation I have adopted a qualitative approach based on in-depth narrative interviews with intersex persons (those medicalized and not), and explorative interviews with privileged informants, such as members of the medical profession and psychologists, and GLBTQ activists. This documentation is part of a broader

10 ISNA was the first intersex association in the USA, founded in 1993 by Cheryl Chase. In 2008 Chase/Bo Laurent moved on from ISNA to become a member of the Advisory Committee of a new association, Accord Alliance (<http://www.isna.org>, <http://www.accordalliance.org/>).

11 <http://oiiinternational.com/>

sociological research I have been conducting through different tools: the qualitative part also consists of a digital ethnography on national and international intersex and dsd associations and organizations, intersex and gender non-conforming web writings, and on my participation to various GLBTQ mailing lists as well as in open and closed intersex/dsd groups in one of the most widespread social networks. The methodology of my whole project is a combination of quantitative (using the few collective data available) and qualitative sociological research.

As Sara Garbagnoli said: «*In Italy sex/gender and sexuality studies are often carried out by courageous and non-academic researchers (often using their own resources) and acting against very powerful institutional resistances opposed to the denaturalization of sexual order and to its inscription in the immanence of history and politics*»¹². My case is no exception, and one of the consequences is that I have had to slow down my efforts in this independent research and to postpone some other research goals, like the interviews to the parents of intersex persons¹³, and the quantitative analysis on some rough collected data I obtained from the Health Agency of the Region of Tuscany (ARS Toscana). At the time of writing, I have done interviews with seven persons with different intersex/dsd variations, and different degrees and types of medicalization¹⁴, three LGBTQ activists¹⁵, and five doctors (four women: a neonatologist, a gynecologist, a geneticist, a neuropsychiatric, and a male surgeon)¹⁶.

Here I will almost exclusively focus on the medicalization of intersex/uality from the medical professional's viewpoint, analyzing the literature, some of the national and international meetings (organized by dsd and medical associations, as well as by intersex activists and scholars), and the in-depth interviews to physicians and the digital ethnography I conducted until now¹⁷.

12 «*In Italia le ricerche su genere, sessualità e "minoranze" sono svolte da coraggiosi studiosi/e (e) militanti (spesso con mezzi economici propri), lottando pervicacemente contro poderosissime resistenze intellettuali e istituzionali che operano per «troncare e sopire» l'atto epistemico sacrilego di fare del sesso non un pilastro di una trascendente lex naturalis, ma una questione propria all'immanenza della storia e di una politica che si voglia radicalmente democratica e del genere, scottianamente, "a primary way of signifying power"*». Written interview with Sara Garbagnoli, expert in gender studies (September 2013). The reduction and translation into English for this paper has been made by Garbagnoli herself.

13 These interviews would have the aim to inquire into the parents' role in the decisions over medical treatments, as well as their expectations, experiences and desires for their children.

14 In respect of persons with an intersex variation, I have tried to analyse their opinions and day-to-day experiences related to the intersex/dsd condition and to the eventual pharmacological, medical, or surgical care they may have had. In this last case, I have asked if they were prepared for those experiences, and how; if, given the choice, they would have postponed medicalization and chosen intervention at a later stage, when they were adults and more aware; or, instead, if they are satisfied with the physical, emotional, and social effects of medicalization.

15 I have sought to determine the level of awareness and knowledge among GLBTQ activists about intersex questions and the links between the GLBTQ associations and intersex activists and dsd associations.

16 I have investigated how doctors deal with intersex of new-borns; what choices and decisions they take and why; how they involve the parents into the decisions (if they do), and how they counsel and treat adult intersex/dsd patients.

17 For a first analysis of intersex/dsd persons and activists' viewpoint see Balocchi (2012).

3. THE SOCIOLOGICAL ASPECTS OF MEDICALIZATION OF INTER-SEX BODIES

My analysis of the management of intersexuality in Italy echoes Kessler's research in the 1990s and demonstrates and confirms that there is a close connection between what is socially accepted as "normal" female and "normal" male, and the decisions and explanations of the medical establishment regarding the cosmetic surgical intervention and the pharmacological treatments. Moreover, beliefs, social norms, prejudices and medical explanations reinforce each other. What strongly emerges from the medical professionals and psychologists' statements during national and international conferences and meetings¹⁸, and from some of the interviews I conducted with doctors, is their concern about the eventual "psycho-social" effects that having non-conforming genitals (meaning in some way different from those of others) or other forms of intersexuality might have on the children and their parents. A gynecologist, talking about male children with a complex situation in which various specialists are called to give an opinion, said: «[Gyn]: *There is a severely inadequate external male genital situation. In such a case, I think, we're facing the real problem; I have to say that the latest procedure path is not to intervene and change sex, but to wait and see what happens. [I]: [...] you said these male children with differing genitals are not considered, in your words, "adequate"...* [Gyn]: *Yes. [I]: Adequate for what, exactly? [Gyn]: For a comparison to their peers, for example*»¹⁹.

But who decides what kinds of genitals and what morphology are considered adequate and "normal"? And what is considered a "normal" woman and a "normal" man?

The criteria for deciding sex assignment have varied over time. Very briefly, during the sixteenth century sex assignment was based on the basic female-male anatomic-physiology (presence of testicles or uterus). Since the second half of the nineteenth century, sex assignment was mostly based on the type of gonads (when both gonads were present, reference was made to an "unsure sex" and attempts were made to discover the "prevalent sex"). Since the twentieth century, sex assignment began to be based on the genetic set (CNB 2010; Busi 2005).

Nowadays a consciousness is emerging that human sex is composed of multiple dimensions: anatomic-physiological, hormonal-gonadic, chromosome-genetic, and psycho-social components. What remains dominant it is the sex and gender dualistic approach to the human variety, notwithstanding the discoveries in biological and ethological area. But «*if nature really offers us more than two sexes, then it follows that our current notions of masculinity and femininity are cultural conceits*» and, above all, the medical and surgical practices performed on

18 Conference on *Tempi e modi della comunicazione della diagnosi al paziente e ai genitori*, September 29, 2012, Rome.

19 I conducted this interview in Florence in June 2009. Here the original version: "[Gyn]: *Ci sono varie situazioni di genitali esterni molto poco adeguati al maschile. Allora lì, secondo me, si pone il problema reale; devo dire che gli ultimi intendimenti sono sicuramente non a cambiare genere ma aspettare e vedere cosa succede [...]. [I]: [...] questi bambini maschi con genitali che variano dalla norma, eh, non vengono, ha detto, non vengono ritenuti "adeguati"...* [Gyn]: *si [I]: ma adeguati a cosa? [Gyn]: no, ad un confronto per dire con coetanei, banalmente pensando a loro.*"

intersex newborns and children appear to be based on the desire to maintain the dominant two-sex/gender system (Fausto Sterling 2000, p.31).

In this cultural frame, it is noteworthy that physicians receive also a lot of pressure from the parents of those born with atypical sexual anatomy or with other differences in the sexual primary or secondary characteristics to “correct” and “normalize” them. This because parents are rarely prepared for an intersex child, since the social silence, ignorance and disregard about intersex reality and intersex issues; so they are frequently unable to face the situation on their own in a balanced way (D’Alberon 2004). About the relation with the parents, a geneticist pointed out: *«It’s true that a strong counselling structure for parents could be created, which would teach them to treat as a female a daughter with a penis etc.; but it is difficult. [...] The relationship with parents is very complex, because they really need support, and instead unfortunately there is no structure for counselling, it must be improvised every time, [...] instead they really need support to hold up an identification of a female or a male without clear genitals: that is a fact»*²⁰.

It clearly emerges the physicians and parents’ anxiety about atypical sexual anatomies, which are considered unacceptable in a society unprepared to welcome the diversity presented by those who are morphologically or anatomically different from the majority. But from the medical professionals, instead of there being a clear statement of the need to change the cultural context to make it more informed, conscious and welcoming, there continues to be a tendency to the pharmacological and surgical “normalization”. This emerges also from a recent interview for the weekly magazine *Left* in which a surgeon and pediatric urologist said: *«There are parents who ask for surgery as soon as possible because they cannot stand the impact, they can’t even stand changing diapers anymore. They are not prepared. Nobody is prepared»*²¹ (Mirenda 2013, p.40). Here it seems that this practitioner unloads the responsibility of the decision to intervene with cosmetic surgery upon the parents of intersex infants, instead of considering the responsibilities of a medical class that should give all the necessary information and accompany the parents through an inevitably delicate process, particularly sensitive in our social context. Despite the quotation marks, it is not ruled out that in this case we are facing a journalistic simplification; in any case too often medical professionals demonstrate being not really prepared to face these issues in Italy, not only from the socio-cultural and gender issues

20 I conducted this interview in Florence in June 2009: *«È vero che ci potrebbe essere un counselling serrato con i genitori che imparano a trattare al femminile una figlia con un fallo, ecc. ma è complesso». [...] «il rapporto con i genitori è complesso, perché loro davvero hanno bisogno di sostegno e lì purtroppo non c’è una cosa strutturata, va improvvisata di volta in volta [...] loro hanno proprio bisogno di un counselling per reggere una identificazione di un femminile o di un maschile senza un genitale chiaro, questo è un dato di fatto che è così»* (Gen).

21 The original version: *«Ma ci sono genitori che chiedono di operare il prima possibile perché sono loro a non reggere l’impatto, sono loro che non ce la fanno nemmeno più a cambiare il pannolino. Non sono preparati. Nessuno è preparato»*.

viewpoint, but sometimes also from a strictly professional one²².

From my interviews, in some cases, the necessity to change the socio-cultural context is stressed only after a solicitation or a direct question²³; in some others there is a consciousness of the socio-cultural pressure even if the professional continues to consider intersexuality as a failure of sexual differentiation and development²⁴. As of today in Italy I have heard only one doctor (a neuropsychiatrist) publicly asserting that intersexuality is a natural variation of the human development (Tonarti 2013).

A report by the San Francisco Human Rights Commission (2005, p.4 & p.14) stated: «*the Commission became concerned that homophobia, transphobia, and heterosexism were strong social forces that contributed to the decision-making process for assigning sex and gender to intersex children through “normalizing” genital surgeries and sex hormone treatments*». And also: «*[e]ven today, the goal of many leading teams treating intersex is still to make intersex disappear. Pediatric endocrinologist Maria New recommends Dexamethazone to women who may be carrying an XX child with Congenital Adrenal Hyperplasia (CAH); these treatments do not alleviate CAH, they only make the child’s clitoris appear smaller, and practitioners hope that it will decrease the likelihood that girls grow up with masculine behaviours or lesbian sexual orientation. Meanwhile, abortion is routinely offered to women who are likely pregnant with children with intersex conditions, including Klinefelter’s Syndrome. Finally, doctors continue constructing vaginas in and performing clitoroplasties on infants and young children, despite arguments by many medical professionals that early genitoplasties fail too often and are unnecessary to begin with*». These same practices and interventions continue to be carried out in Italy too²⁵.

22About the invisibilization of intersexuality in the Italian media, due in part to the journalists' general misinformation (and often ignorance) on the issue, in a context of overall low level of journalism, see Balocchi (2011); about this last topic combined to the questionable statements released by some doctors to the press, see also Balocchi -Tonarti (2014).

23This is the case of the gynaecologist (and also the neonatologist) I interviewed, who focused on the socio-cultural difficulties in accepting the differences in general and not merely on the sexual and gender differences: «*I think there is a key issue which has to do with differences in general, not only gender differences. Thus, intersexuality, like any other difference, is simply not accepted, I think that the work of acceptance needs to be really wide-ranging, but it does not seem to me that we are following this path right now, are we? Take immigration: this is not an ideologically propitious moment for really being able to*» (here the original version: «*lo penso che c'è un tema di lavoro sulle differenze, e non differenze di genere, che è ancora a monte di questa situazione qui, quindi non si accoglie l'intersessualità come non si accoglie il diverso, la differenza in assoluto. Io penso che il lavoro di accoglimento è generale, purtroppo non mi sembra che stiamo andando in questa direzione in questo momento, no? Pensiamo all'immigrazione... non è il momento ideologico in cui si accoglie molto l'altro da noi. Nel tema dell'intersessualità c'è una paura, c'è soprattutto una paura maschile di un non funzionamento, non c'è dubbio che è così. Come c'è con l'omosessualità, c'è una paura: uno deride quel che gli fa paura. Il tema vero è riflettere sulle differenze e non-differenze interumane, di cui questo è un sottogruppo un po' speciale, ma che se non si agganciasse a una propria paura non darebbe tutto questo tipo di problematica*» Florence, June 2009).

24 *L'intersessualità nella Società Italiana*: <http://www.radioradicale.it/scheda/311598/lintersessualita-nella-societa-italiana>

25 See the life-stories narrated by some Italian women “patients” with Androgen Insensitivity and collected in the AISIA (Associazione Italiana Sindrome Insensibilità Androgeni) website <http://www.sindromedimorris.org/storie.html>.

It should not be forgotten that, if there have been some changes in the international medical protocols and guidelines, it is because of a strong negotiation between intersex organizations and activists, supported by some scholars and few medical professionals²⁶, and the medical class still anchored to the John Hopkins model²⁷. Nevertheless, those protocols are still tainted by some prejudices linked to the rigid sex/gender dimorphism and heteronormativity. From the Mattioli and Jasonni's review (2004) of the medical protocols on management of intersexuality and sex/gender assignment, it can be inferred that they are still influenced by: a) the physical appearance of the genitals (such as the dimension of the penis and clitoris, and the depth of the vagina); b) the genitals' capacity to fulfil their "sexual functions" (the hypothetical "right" dimension of the penis for sexual penetration, and the ability of the vagina to hold a penis); c) the potential results of aesthetic surgeries always in an heteronormative and "reproductive" frame (which comprehend, for example, the reduction of a hypertrophic clitoris because it is deemed inappropriate for a woman to have a "clito-penis" with which she could penetrate another woman, or "even" a man). As we see, those considerations also cover the possible (non-conform) sexual orientation of the patient.

Speaking about the reasons that compel Italian doctors, psychiatrists and psychologists to maintain the old protocols despite the newest international literature and guidelines, as well as the increasing number of intersex/dsd persons exposing the painful, irreversible effects of those practices, the psychologist D'Alberton (2012) cites the concept of "cognitive complaisance" by Andrea Scardovi, a psychoanalyst from Bologna. With this concept Scardovi refers to «*an unconscious tendency to assign a primacy in value and significance to something that we perceive as external from us and that we suppose is objectifiable, in order to relieve us from the responsibility of direct relationships, in accordance to a deep and mysterious need for delegation. It is a limitation of our responsibility toward others, a defense put in place against excessive contact, but that also expresses an internal difficulty to allowing ourselves to think freely and independently; a "certainty" on which to rely, displaying an adherence in which the more we delegate, the more we feel compliant, or "just" because of our obedience*». According to D'Alberton, this tendency has characterized, and still characterizes, the way in which the medical and psychological class has traditionally managed intersexuality/dsd in Italy. Until the intersex/dsd associations have made their voices heard, there were little doubts among the

26 Such as Anne Fausto Sterling, Milton Diamond, Suzanne Kessler, and Alice Dreger, to do some example.

27 The interventionist protocol was born under the influence of John Money and his team's experimentations at John Hopkins University, where they postulated the psychosexual neutrality of the infant and maintained that a healthy development depended first and foremost on the genital apparatus' appearance and on a clear assigned gender education within the second year of life. For decades the dominant field of thought has postulated that letting a child grow up with atypical genitals would irreversibly damage her/his psyche and would result in social difficulties. This approach came to be known as the "optimum gender of rearing" model. As underlined in the San Francisco Commission report: «*The basic idea was that each child's potential for a "normal" gender identity should be maximized by making each child's body, upbringing, and mind align as much as possible. Because of the belief that it was harder to surgically engineer a boy than a girl, most children with intersex were made as feminine as possible, utilizing surgery, endocrinology, and psychology. A "successful" patient was one judged to be stable and "normal" (i.e., heterosexual and gender-conforming) in the assigned gender*» (Idem p.12).

operators that the cases of intersex/dsd should be treated according to the “Traditional Treatment Paradigm”, a set of implicitly accepted and usually undisputed rules derived from the aforementioned J. Hopkins model of the “optimal gender of rearing”.

4. SOME FINAL CONSIDERATIONS AND A LOOK AT THE ONGOING CHANGES

In Italy the intersex issue remains mostly uninquired in the Academy; the scientific literature is scarce and the majority of the research on the subject has been conducted in the medical sector, looking at intersexuality only as a medical issue and a rare disease; moreover, intersexuality is still almost invisible at wider socio-cultural level. The Italian situation is characterized by the scarcity of quantitative and qualitative data on the topic, and also the scarcity of sociological and humanistic literature on the issue: there is currently no sociological monograph on the matter, and I have been the first one to write on the medicalization of intersexuality from a sociological viewpoint in my country²⁸.

Actually, several considerations about the management of intersexuality emerge:

a) the socio-cultural stereotypes defining “normal” femininity and masculinity continue to have a strong direct and indirect influence on the physicians and parents’ decisions, more or less consciously and critically related to the social-cultural contexts and personal awareness;

b) those gender stereotypes are linked to the heterosexual and gender-conforming orthodoxy and to the homo/heterosexual dichotomy, where only the hetero and gender-conform pole is considered and accepted as right, “normal” and healthy;

c) the dominant protocol continues to be intervention with aesthetic surgery even in the absence of pathology. These practices are now starting to be questioned thanks to the debate with some self-help Italian DSD groups and associations (like AISIA), and to the pressure of some individual Italian activists, scholars, and groups (like intersexioni), which have been contributing to build an intersex rights movement²⁹. So, even if they actually seem to be a minority, some medical professionals and psychologists have started to act more sensitively and more carefully toward the needs and the well-being of people, rather than pressuring them toward normalization.

It is useful to underline that at international level for the first time, during the course of 2013, there have been important statements from at least three relevant international institutions: in June 2013, the Foreign Affairs Council of the European Union adopted guidelines to promote and protect the enjoyment of all human rights by sexual minorities, including intersex persons.

²⁸ In this regard, in the humanities area, only a few degree dissertations are focused on intersex issues (such as the sociological one by Nicole Braidà, and two anthropological ones by Roberta De Nardi and Valentina Fineo, still unpublished); and only a few pioneering essays and books have been published (by Bernini 2010, Busi 2012, Monceri 2010, Tripodi 2011, from a philosophical viewpoint; by Crocetti, 2013 from an anthropological one).

²⁹ www.intersexioni.it; www.sindromedimorris.org, last accessed April 2014.

In March, the United Nations Special Report on Torture recommended the member States to avoid unnecessary surgical and pharmacological interventions often used to “normalize” primary and secondary sexual characteristics in intersex children. Finally, in October the Parliamentary Assembly of the Council of Europe adopted a historical intersex resolution addressing, again for the first time ever, the issue of bodily integrity and self-determination of intersex children. The associations Ilga Europe and OII Europe welcomed this resolution that, as they stressed, calls upon the Member States of the Council of Europe to “*undertake further research to increase knowledge about the specific situation of intersex people, ensure that no-one is subjected to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to persons concerned, and provide families with intersex children with adequate counselling and support*”³⁰.

It is supposed that these international resolutions, guidelines and recommendations, remarked by the Italian activists and scholars, could have positive consequences on the viewpoint on intersex issues, contributing to the change of the medical protocols and practises in the management of intersexuality in Italy too. Otherwise, until now there have been very few doctors who have taken a public stand exposing the effects of the pathologizing of intersexuality in its various forms.

It is interesting in this regard that during a conference organised by Onig (the National observatory on gender identity in Italy, an association in which part of the members is involved in the management of intersexuality) and the University of Naples Federico II³¹, a trans activist urged the guest speakers to express the position of Onig on the current debate about intersex cosmetic surgeries. On that occasion the roundtable moderator, a psychotherapist, expressed her aversion toward the aesthetic interventions, asserting that the majority of Onig members would answer in the same way (Botteghi 2013). It must be noted, though, that until now there has not been any official statement from this national association on such a crucial issue. In the meantime, Onig has created an internal work group on the “DSD” (composed of physicians and psychologists-psychotherapists). It is interesting that, some months before, a closed group was formed on the social network Facebook with the name “For Intersex Rights”, with this motivation: “*This group was born to examine this issues, on which is currently undergoing a serious scientific debate regarding ethics, medicine, psychology and sociology. It raises complex questions, such as, for example: can genital atypical affect sexual identity, gender identity or sexual orientation of a person? And are surgical correction of sex reassignment appropriate at the birth? Just to talk about it together. Care of University of Naples 'Federico*

30 http://www.ilga-europe.org/home/news/for_media/media_releases/parliamentary_assembly_of_the_council_of_europe_adopts_historical_intersex_resolution. Here the text of the Resolution 1952 (2013): <http://www.assembly.coe.int/nw/xml/XRef/X2H-Xref-ViewPDF.asp?FileID=20174&lang=en> (last accessed April 2014).

31 www.onig.it. The current president of Onig is a professor of Clinical Psychology at the University of Naples Federico II.

///.³² If the good intentions and purposes are clear, the questions posed are quite baffling: a) the first one shows a genital reading of gender identity and sexual orientation that we assumed to be completely outdated by now, since these three aspects can be interconnected (and for the majority of people are “conform”), but there is not necessarily a direct connection, as transgenderism and the different kinds of sexual orientation (hetero, homo, bisex, pansexual, asexual³³, etc.) show. b) The same goes for the second question, which seems to ignore the international literature of the last 20 years, the increasingly numerous testimonies of intersex persons since the early Nineties, as well as the international (and more recently national) current debate and the international recommendations to ensure the bodily integrity of infants and children. The second question could be more appropriate if it focused on monitoring the Italian situation, on increasing knowledge about the experiences of Italian intersex people, sharing information, and giving assistance³⁴.

At the beginning of this paper I said that, given the extreme human (and animal) biological variability (amply supported by scientific research, by now), the pathologization and medicalization of human intersex differences and the consequent invisibilization could seem a paradox, if they were not the product of a rigid sex/gender binary system, where the parameter that defines the condition of “normality” is identified in the dualism female/male, with a conform sexual anatomy and gender identity (woman/man), and an orthodox sexual orientation (hetero and not homosexual, without considering any other possible sexual orientation). But this rigid dual dimorphism is not universal, and in other past and present socio-cultural systems there are expected and accepted other forms of being which do not fix in the sex/gender dichotomy. For example, the *guevedoche* in the Dominican Republic and the *nàdleehì* or *two spirits* in the Navajo, Pueblo, and Mohave are examples of societies in which a non-binary gender or a “third gender” is socially and politically recognized (Baird 2003, Bisogno).

The socio/political/anatomic continuity between the medicalization of intersexuality and intersex bodies and the pathologization of transsexuality and gender variant persons can be detectable in the attempt to stabilize the sex/gender binarism anchoring it to the “genitalism” of the bio-medical, psychiatric and psychoanalytic discourse (Arfini 2007, Busi 2012).

Nevertheless, it is rational and predictable (thanks to the intellectual and scientific progresses and to the pressure by intersex/dsd people and activists), as well as desirable (for a true respect and widening of human rights), that the consideration and interpretation of intersexuality will follow the same path of minority sexual orientations and of gender variants. It is useful to remind that the American Psychiatric Association has removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1973, and that the World

32 As we can read, the group is managed by the University of Naples Federico II, in particular by some psychologist-psychotherapists. <https://www.facebook.com/groups/forintersexrights/> (last accessed April 2014).

33 <http://asexuality.org/it/>; <http://asessuali.wordpress.com/> (last accessed April 2014).

34 Considering the circumstances it is not surprising that the group, notwithstanding its 1111 members on April 28th, is almost entirely inactive and is especially not perused by intersex/dsd people nor by the few Italian scholars who work in the field.

Health Organization (WHO) removed it from the International Classification of Diseases (ICD) seven years later; nowadays it is considered a natural manifestation of human sexuality. About transsexuality, as I wrote, there has been a wide debate on its depathologization, and in the new DSM-5 its definition has changed in “dysphoria” of gender identity instead of “disturb”.

Considering the differences between sexual orientation, gender identity and variations in sexual development, and in sight of their acknowledgement and acceptance, I guess the time will come for a full recognition of the conditions of non-conforming gender identities and of the differences in sexual development as natural variations in human beings to be welcomed and respected.

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